# CORPORATE INTEGRITY AGREEMENT
BETWEEN THE
OFFICE OF INSPECTOR GENERAL
OF THE
DEPARTMENT OF HEALTH AND HUMAN SERVICES
AND
ALEXANDER BENENSON, M.D. AND
BROOKLYN MEDICAL SCANNING, P.C.

## I. PREAMBLE

Alexander Benenson, M.D. ("Benenson") and Brooklyn Medical Scanning, P.C. ("BMS") (BMS and Benenson shall be collectively referred to as "Benenson," unless otherwise noted) hereby enter into this Corporate Integrity Agreement ("CIA") with the Office of Inspector General ("OIG") of the United States Department of Health and Human Services ("HHS") to promote compliance with the statutes, regulations, program requirements and written directives of Medicare, Medicaid, and all other Federal health care programs (as defined in 42 U.S.C. § 1320a-7b(f)) ("Federal health care program requirements"). This commitment to promote compliance applies to any entity that Benenson owns or in which Benenson has a control interest, as defined in 42 U.S.C. § 1320a-3(a)(3), including BMS, and any such entity's employees, agents, contractors and all third parties with whom Benenson or such entity may choose to engage to act as billing or coding consultants for the purposes of claiming reimbursement from the Federal health care programs ("Covered Persons"). Contemporaneously with this CIA, Benenson is entering into a Settlement Agreement with the United States, and this CIA is incorporated by reference into the Settlement Agreement.

## II. TERM OF THE CIA

Except as otherwise provided, the period of compliance obligations assumed by Benenson under this CIA shall be three (3) years from the effective date of this CIA. The effective date of this CIA shall be the date on which the final signatory of this CIA executes this CIA ("Effective Date").

Sections VII, VIII, IX, X and XI shall expire no later than 120 days from OIG's receipt of: (1) Benenson's final annual report; or (2) any additional materials submitted by Benenson pursuant to OIG's request, whichever is later.

## III. INTEGRITY OBLIGATIONS

Benenson shall establish a Compliance Program that, at minimum, includes the following elements:

### A. Compliance Contact

If Benenson is not the Compliance Contact, then within thirty (30) days of execution of this CIA, Benenson shall designate a person to be the Compliance Contact for the purposes of developing and implementing policies, procedures and practices designed to ensure compliance with the obligations herein and with Federal health care program requirements. In addition, the Compliance Contact is responsible for responding to questions and concerns from Covered Persons and OIG regarding compliance with the CIA obligations. The name and phone number of the Compliance Contact shall be included in the Implementation Report. In the event a new Compliance Contact is appointed during the term of this CIA, Benenson shall notify OIG, in writing, within fifteen (15) days of such a change.

### B. Posting of Notice

Within the first thirty (30) days following the Effective Date of this CIA, Benenson shall post in a prominent place accessible to all patients and Covered Persons a notice detailing his commitment to comply with all Federal health care program requirements in the conduct of his business. This notice shall include a means (i.e., telephone number, address, etc.) by which instances of misconduct may be reported anonymously. A copy of this notice shall be included in the Implementation Report. An example of such a notice is attached as Attachment 2.

### C. Written Policies and Procedures

Within ninety (90) days of the Effective Date of this CIA, Benenson shall develop, implement, and make available to all Covered Persons written policies that address the following:

1. Benenson's commitment to operate his business in full compliance with all Federal health care program requirements;

2. A requirement that all Covered Persons shall be expected to comply with all Federal health care program requirements and with Benenson's own Policies and Procedures as implemented pursuant to Section III.C

(including the requirements of this CIA);

3. The requirement that all of Benenson's Covered Persons shall be expected to report to Benenson or the Compliance Contact suspected violations of any Federal health care program requirements or Benenson's own Policies and Procedures. Any Covered Person who makes an inquiry regarding compliance with Federal health care program requirements shall be able to do so without risk of retaliation or other adverse effect;

4. The requirement that Benenson shall not hire as employees or engage as contractors any Ineligible Person. For the purposes of this CIA, an "Ineligible Person" shall be any individual or entity who: (i) is currently excluded, debarred, suspended, or otherwise ineligible to participate in the Federal health care programs or in Federal procurement or non-procurement programs; or (ii) has been convicted of a criminal offense that falls within the ambit of 42 U.S.C. § 1320a-7(a), but has not yet been excluded, debarred, suspended, or otherwise declared ineligible. To prevent hiring or contracting with any Ineligible Person, Benenson shall check all prospective employees and contractors prior to engaging their services against the HHS/OIG List of Excluded Individuals/Entities (available through the Internet at http://oig.hhs.gov ) and the General Services Administration's List of Parties Excluded from Federal Programs (available through the Internet at http://epls.arnet.gov). In addition to prospective checks, Benenson shall conduct annual checks of all employees against each exclusion list;

5. Benenson's commitment to remain current with all Federal health care program requirements by obtaining and reviewing program memoranda, newsletters, and any other correspondence from the carrier related to Federal health care program requirements;

6. The proper procedures for the accurate preparation and submission of claims in accordance with Federal health care program requirements;

7. The proper documentation of services and billing information and the retention of such information in a readily retrievable form; and

8. The requirement that all claims submitted to the Federal health care programs be accurate, fully and adequately document the services performed, and reflect the level of service performed.

At least annually (and more frequently if appropriate), Benenson shall assess and update as necessary the Policies and Procedures. Within thirty (30) days of the Effective Date of any revisions, the relevant portions of any such revised Policies and Procedures shall be made available to all individuals whose job functions are related to those Policies and Procedures.

Within ninety (90) days of the Effective Date of the CIA, and annually thereafter, each Covered Person shall certify in writing that he or she has read, understood, and shall abide by Benenson's Policies and Procedures. New Covered Persons shall review the Policies and Procedures and shall complete the required certification within fifteen (15) days after becoming a Covered Person or within ninety (90) days of the Effective Date of the CIA, whichever is later.

Copies of the written Policies and Procedures shall be included in the Implementation Report. Copies of any written Policies and Procedures that are subsequently revised shall be included in Annual Reports.

## D. Training and Certification

Within ninety (90) days following the Effective Date of this CIA, and at least once each year thereafter, Benenson and Covered Persons involved in the delivery of patient care items or services and/or in the preparation or submission of claims for reimbursement from any Federal health care program shall receive at least four (4) hours of training from an individual or entity, other than Benenson or another Covered Person. The training shall be conducted by individuals with expertise in the relevant subject areas, e.g., preparation or submission of claims to Federal health care programs for the types of services provided by Benenson and may be received from a variety of sources (i.e., CME classes, hospitals, associations, carriers).

New Covered Persons involved in the delivery of patient care items or services and/or in the preparation or submission of claims for reimbursement from any Federal health care program shall receive the training described above within thirty (30) days after becoming a Covered Person or within ninety (90) days of the Effective Date of this CIA, whichever is later. The training for New Covered Persons may either be provided internally by Covered Persons who have completed the required annual training or externally by a qualified individual or entity. Until they have received the requisite training, such New Covered Persons shall work under the direct supervision of a Covered Person who has received such training.

At a minimum, the annual and new Covered Person training sessions shall cover

the following topics:

1. Federal health care program requirements related to the proper submission of accurate bills for services rendered and/or items provided to Federal health care program patients;

2. The written Policies and Procedures developed pursuant to Section III.C, above;

3. The legal sanctions for improper billing or other violations of the Federal health care program requirements; and

4. Examples of proper and improper billing practices.

Each Covered Person shall annually certify in writing that he or she has received the required training. The certification shall specify the type of training received and the date received. Benenson shall retain the certifications, along with the training course materials. The training course materials shall be provided in the Annual Report.

For the purposes of this Section III.D, Benenson shall receive credit for any training provided to Covered Persons since September 1, 2002.

E. Third Party Billing

Benenson represents that he does not presently contract with a third party billing company to submit claims to the Federal health care programs. Benenson represents that, should he contract with a third party billing company in the future, he shall not have an ownership or control interest (as defined in 42 U.S.C. § 1320a-3(a)(3)) in the third party billing company and shall not be employed by, nor act as a consultant to, such third party billing company. If Benenson intends to obtain an ownership or control interest (as defined in 42 U.S.C. § 1320a-3(a)(3)) in, or become employed by, or become a consultant to, any third party billing company during the term of this CIA, Benenson shall notify OIG thirty (30) days prior to any such proposed involvement.

Should Benenson contract with a third party billing company during the term of this CIA, Benenson shall obtain and include in the next Annual Report a certification from the third party billing company that (i) it is presently in compliance with all Federal health care program requirements as they relate to submission of claims to the Federal health care programs; (ii) it has a policy of not knowingly employing any person who has been excluded, debarred, suspended, or declared ineligible to participate in Medicare or

other Federal health care programs, and who has not yet been reinstated to participate in those programs; and (iii) it provides the required training in accordance with Section III.D of the CIA for those employees involved in the preparation and submission of claims to Federal health care programs. If Benenson contracts with a third party billing company during the term of this CIA, Benenson shall, within thirty (30) days of entering into such contract, obtain and send to OIG the certification described in this Paragraph.

E. Review Procedures.

1. *General Description.*

a. Retention of Independent Review Organization. Within ninety (90) days of the Effective Date, Benenson shall retain an entity (or entities), such as an accounting, auditing, or consulting firm (hereinafter "Independent Review Organization" or "IRO"), to perform reviews to assist Benenson in assessing and evaluating his billing and coding practices and certain compliance obligations pursuant to this CIA and the Settlement Agreement. Each IRO retained by Benenson shall have expertise and/or knowledge in the billing, coding, reporting, and other requirements of the particular section of the health care industry pertaining to this CIA and in the general requirements of the Federal health care program(s) from which Benenson seeks reimbursement. Each IRO shall assess, along with Benenson, whether it can perform the IRO review in a professionally independent and/or objective fashion, as appropriate to the nature of the engagement, taking into account any other business relationships or other engagements that may exist. The IRO(s) review shall address and analyze Benenson's billing and coding to the Federal health care programs ("Claims Review").

b. Frequency of Claims Review. The Claims Review shall be performed annually and shall cover each of the one-year periods of the CIA beginning with the Effective Date. The IRO(s) shall perform all components of each annual Claims Review.

c. Retention of Records. The IRO and Benenson shall retain and make available to OIG, upon request, all work papers, supporting documentation, correspondence, and draft reports (those exchanged between the IRO and Benenson) related to the reviews.

2. *Claims Review*. The Claims Review shall include a Discovery Sample and, if necessary, a Full Sample. The applicable definitions, procedures, and reporting requirements are outlined in Appendix A to this CIA , which is incorporated by reference.

a. Discovery Sample. The IRO shall randomly select and review a sample of fifty (50) Paid Claims submitted by or on behalf of Benenson. The Paid Claims shall be reviewed based on the supporting documentation available from Benenson (or under Benenson's control) and applicable billing and coding regulations and guidance to determine whether the claim submitted was correctly coded, submitted and reimbursed.

i. If the Error Rate (as defined in Appendix A) for the Discovery Sample is less than 5%, no additional sampling is required, nor is the Systems Review required. (Note: The threshold listed above does not imply that this is an acceptable error rate. Accordingly, Benenson should, as appropriate, further analyze any errors identified in the Discovery Sample. Benenson recognizes that OIG or another HHS component, in its discretion and as authorized by statute, regulation, or other appropriate authority may also analyze or review Paid Claims included, or errors identified, in the Discovery Sample.

ii. If the Discovery Sample indicates that the Error Rate is 5% or greater, the IRO shall perform a Full Sample and a Systems Review, as described below.

b. Full Sample. If necessary, as determined by procedures set forth in Section III.E.2.a, the IRO shall perform an additional sample of Paid Claims using commonly accepted sampling methods and in accordance with Appendix A. The Full Sample should be designed to (1) estimate the actual Overpayment in the population with a 90% confidence level and with a maximum relative precision of 25% of the point estimate and (2) conform with the Centers for Medicare and Medicaid Services' ("CMS") statistical sampling for overpayment estimation guidelines. The Paid Claims shall be reviewed based on supporting documentation available from Benenson (or under Benenson's control) and applicable billing and coding regulations and guidance to determine whether the claim submitted was correctly coded, submitted, and reimbursed. For the

purposes of calculating the size of the Full Sample, the Discovery Sample may serve as the probe sample, if statistically appropriate. Additionally, Benenson may use the Items sampled as part of the Discovery Sample, and the corresponding findings for those 50 Items, as part of the Full Sample. OIG, in its full discretion, may refer the findings of the Full Sample (and any related workpapers) received from Benenson to the appropriate Federal health care program payor, including the Medicare contractor (e.g., carrier, fiscal intermediary, or DMERC), for appropriate follow-up by that payor.

c. Systems Review. If Benenson's Discovery Sample identifies an Error Rate of 5% or greater, Benenson's IRO shall also conduct a Systems Review. Specifically, for each claim in the Discovery Sample and Full Sample that resulted in an Overpayment, the IRO should perform a "walk through" of the system(s) and process(es), that generated the claim to identify any problems or weaknesses that may have resulted in the identified Overpayments. The IRO shall provide to Benenson observations and recommendations on suggested improvements to the system(s) and the process(es) that generated the claim.

d. Repayment of Identified Overpayments. In accordance with Section III.F.1 of the CIA , Benenson shall repay within thirty (30) days any Overpayment(s) identified in the Discovery Sample or the Full Sample (if applicable), regardless of the Error Rate, to the appropriate payor and in accordance with payor refund policies. Benenson shall make available to OIG any and all documentation that reflects the refund of the Overpayment(s) to the payor and the associated documentation.

3. *Claims Review Report.* The IRO shall prepare a report based upon the Claims Review performed (the "Claims Review Report"). Information to be included in the Claims Review Report is detailed in Appendix A.

4. *Validation Review.* In the event OIG has reason to believe that: (a) Benenson's Claims Review fails to conform to the requirements of this CIA; or (b) the IRO's findings or Claims Review results are inaccurate, OIG may, at its sole discretion, conduct its own review to determine whether the Claims Review complied with the requirements of the CIA and/or the findings or Claims Review results are inaccurate ("Validation Review"). Benenson shall pay for the reasonable cost of any such review

performed by OIG or any of its designated agents so long as it is initiated before one year after Benenson's final submission (as described in Section II) is received by OIG.

Prior to initiating a Validation Review, OIG shall notify Benenson of its intent to do so and provide a written explanation of why OIG believes such a review is necessary. To resolve any concerns raised by OIG, Benenson may request a meeting with OIG to discuss the results of any Claims Review submissions or findings; present any additional or relevant information to clarify the results of the Claims Review to correct the inaccuracy of the Claims Review; and/or propose alternatives to the proposed Validation Review. Benenson agrees to provide any additional information as may be requested by OIG under this Section in an expedited manner. OIG will attempt in good faith to resolve any Claims Review with Benenson prior to conducting a Validation Review. However, the final determination as to whether or not to proceed with a Validation Review shall be made at the sole discretion of OIG.

5. *Independence/Objectivity Certification.* The IRO shall include in its report(s) to Benenson a certification or sworn affidavit that it has evaluated its professional independence and/or objectivity, as appropriate to the nature of the engagement, with regard to the Claims Review and that it has concluded that it was, in fact, independent and/or objective.

## F. Reporting of Overpayments and Material Deficiencies

1. *Overpayments.*

*a. Definition of Overpayments.* For the purposes of this CIA, an "overpayment" shall mean the amount of money Benenson has received in excess of the amount due and payable under any Federal health care program requirements. Benenson may not subtract any underpayments for purposes of determining the amount of relevant "overpayments" for the purposes of reporting under this CIA.

*b. Reporting of Overpayments.* If, at any time, Benenson identifies or learns of any overpayments, Benenson shall notify the payor (e.g., Medicare fiscal intermediary or carrier) within thirty (30) days of identification of the overpayment and take remedial steps within sixty (60) days of identification (or such additional time as may be agreed to by the payor) to correct the problem, including preventing the underlying problem and the overpayments from recurring. Also, within thirty (30) days of identification of the overpayment,

Benenson shall repay the overpayment to the appropriate payor to the extent such overpayment has been quantified. If not yet quantified, within thirty (30) days of identification, Benenson shall notify the payor of its efforts to quantify the overpayment amount along with a schedule of when such work is expected to be completed. Notification and repayment to the payor shall be done in accordance with the payor's policies, and for Medicare contractors, shall include the information contained on the Overpayment Refund Form, provided as Appendix B to this CIA. Notwithstanding the above, notification and repayment of any overpayment amount that routinely is reconciled or adjusted pursuant to Policies and Procedures established by the payor shall be handled in accordance with such Policies and Procedures.

2. *Material Deficiencies.*

*a. Definition of Material Deficiency.* For the purposes of this CIA, a "Material Deficiency" means anything that involves:

(i) a substantial overpayment; or

(ii) a matter that a reasonable person would consider a probable violation of criminal, civil, or administrative laws applicable to any Federal health care program for which penalties or exclusion may be authorized.

A Material Deficiency may be the result of an isolated event or a series of occurrences.

*b. Reporting of Material Deficiencies.* If Benenson determines, by any means, that there is a Material Deficiency, Benenson shall notify OIG, in writing, within thirty (30) days of making the determination that the Material Deficiency exists. The report to OIG shall include the following information:

(i) If the Material Deficiency results in an overpayment, the report to OIG shall be made at the same time as the notification to the payor required in Section III.F.1, and shall include all of the information on the Overpayment Refund Form, as well as:

(A) the payor's name, address, and contact person to whom the overpayment was sent; and

(B) the date of the check and identification number (or electronic transaction number) on which the overpayment was repaid/refunded.

(ii) a complete description of the Material Deficiency, including the relevant facts, persons involved, and legal and Federal health care program authorities implicated;

(iii) a description of Benenson's actions taken to correct the Material Deficiency; and

(iv) any further steps Benenson plans to take to address the Material Deficiency and prevent it from recurring.

### G. Notification of Government Investigations or Legal Proceedings

Within thirty (30) days of discovery, Benenson shall notify OIG, in writing, of any ongoing investigation known to Benenson or legal proceeding conducted or brought by a governmental entity or its agents involving an allegation that Benenson has committed a crime or has engaged in fraudulent activities. This notification shall include a description of the allegation, the identity of the investigating or prosecuting agency, and the status of such investigation or legal proceeding. Benenson shall also provide written notice to OIG within thirty (30) days of the resolution of the matter, and shall provide OIG with a description of the findings and/or results of the proceedings, if any.

## IV. New Business Units, Locations or Relationships

In the event that Benenson changes locations or sells, closes, purchases or establishes a new business related to the furnishing of items or services that may be reimbursed by Federal health care programs, Benenson shall notify OIG of this fact as soon as possible, but no later than within thirty (30) days of the date of change of location, sale, closure, purchase or establishment. This notification shall include the location of the new operation(s), phone number, fax number, Medicare provider or supplier number(s) (if any), and the corresponding contractor's name and address that has issued each Medicare provider number. All Covered Persons at such locations shall be subject to the applicable requirements in this CIA (e.g., completing certifications and undergoing training).

Prior to Benenson's entering into an employment or contractual relationship with another party related to the furnishing of items or services that may be reimbursed by Federal health care programs, Benenson shall notify that party of this CIA. This notification will include a copy of the CIA, the remaining reporting period(s) of the CIA, and a summary of Benenson's obligations under the CIA. In addition, Benenson shall notify OIG of such relationship as described in Section XI.D of this CIA.

## V. REPORTS

### A. Implementation Report

Within one hundred and twenty (120) days after the Effective Date of this CIA, Benenson shall submit a written report to OIG summarizing the status of his implementation of the requirements of this CIA. This report, known as the "Implementation Report," shall include:

1. The name, address and phone number of Benenson's Compliance Contact;

2. A copy of the notice Benenson posted in his office as described in Section III.B and a description of where and when the notice has been posted;

3. A copy of the written Policies and Procedures required by Section III.C of this CIA;

4. A certification signed by Benenson attesting that the Policies and Procedures are being implemented and have been made available to all Covered Persons;

5. A copy of all training materials used for the training required by Section III.D, a description of the training, including a summary of the topics covered, the length of the session(s) and a schedule of when the training session(s) were held;

6. A certification signed by Benenson attesting that all Covered Persons have completed the initial training required by Section III.D and have executed the required certifications;

7. A copy of the certification from the third party billing company required by Section III.E of the CIA;

8. The name and qualifications of the IRO(s) engaged by Benenson, a summary/description of all engagements between Benenson and the IRO(s), including, but not limited to, any outside financial audits, compliance program engagements, or reimbursement consulting, and the proposed start and completion dates of the first annual review;

9. A certification from the IRO(s) regarding its professional independence and/or objectivity from Benenson;

10. A list of all of Benenson's locations (including locations and mailing addresses), the corresponding name under which each location is doing business, the corresponding phone numbers and fax numbers, each location's Medicare provider identification number(s) and the name and address of the Medicare contractor to which Benenson currently submits claims; and

11. A certification from Benenson stating that he has reviewed the Implementation Report, he has made a reasonable inquiry regarding its content and believes that, upon such inquiry, the information is accurate and truthful.

## B. Annual Reports

Benenson shall submit to OIG Annual Reports with respect to the status of and findings regarding Benenson's compliance activities for each of the three (3) one-year periods beginning on the Effective Date of this CIA. (The one-year period covered by each Annual Report shall be referred to as "the Reporting Period"). The first Annual Report shall be received by OIG no later than sixty (60) days after the end of the first Reporting Period. Subsequent Annual Reports shall be received by OIG no later than the anniversary date of the due date of the first Annual Report.

Each Annual Report shall include:

1. If revisions were made to the written Policies and Procedures developed pursuant to Section III.C of this CIA, a copy of any Policies and Procedures that were revised;

2. A certification by Benenson that all Covered Persons have executed the annual Policies and Procedures certification required by Section III.C;

3. A schedule, topic outline and copies of the training materials for the training programs attended in accordance with Section III.D of this CIA;

4. A certification signed by Benenson certifying that he is maintaining written certifications from all Covered Persons that they received training pursuant to the requirements set forth in Section III.D of this CIA ;

5. A complete copy of all reports prepared pursuant to the IRO's Billing Engagement, including the Claims Review Report, along with a copy of the IRO's engagement letter;

6. Benenson's response and corrective action plan(s) related to any issues raised or recommendations made by the IRO;

7. A summary/description of all engagements between Benenson and the IRO, including, but not limited to, any outside financial audits, compliance program engagements, or reimbursement consulting, if different from what was submitted as part of the Implementation Report;

8. A certification from the IRO(s) regarding its professional independence and/or objectivity from Benenson;

9. A summary of Material Deficiencies (as defined in Section III.F) identified during the Reporting Period and the status of any corrective and preventative action relating to all such Material Deficiencies;

10. A summary describing any ongoing investigation or legal proceeding required to have been reported pursuant to Section III.G. The summary shall include a description of the allegation, the identity of the investigating or prosecuting agency, and the status of such investigation or legal proceeding;

11. A certification, signed by Benenson, that all prospective employees and contractors are being screened against the HHS/OIG List of Excluded Individuals/Entities and the General Services

Administration's List of Parties Excluded from Federal Programs; and

12. A certification, signed by Benenson, that he has reviewed the Annual Report, he has made a reasonable inquiry regarding its content and believes that, upon such inquiry, the information is accurate and truthful.

## VI. NOTIFICATIONS AND SUBMISSION OF REPORTS

Unless otherwise stated subsequent to the execution of this CIA, all notifications and reports required under the terms of this CIA shall be submitted to the following:

OIG:
Administrative and Civil Remedies Branch
Office of Counsel to the Inspector General
Office of Inspector General
U.S. Department of Health and Human Services
Cohen Building, Room 5527
330 Independence Avenue, SW
Washington, DC 20201
Telephone 202-619-2078
Facsimile 202-205-0604

Benenson:
Alexander Benenson, M.D.
Brooklyn Medical Scanning, P.C.
3043 Ocean Avenue, Suite 107
Brooklyn, NY 11235
Telephone 718-891-2727
Facsimile 718-891-2797

Unless otherwise specified, all notifications and reports required by this CIA may be made by certified mail, overnight mail, hand delivery or other means, provided that there is proof that such notification was received. For the purposes of this requirement, internal facsimile confirmation sheets do not constitute proof of receipt.

## VII. OIG INSPECTION, AUDIT AND REVIEW RIGHTS

In addition to any other rights OIG may have by statute, regulation, or contract, OIG or its duly authorized representative(s) may examine or request copies of Benenson's books, records, and other documents and supporting materials and/or conduct on-site

reviews of any of Benenson's locations for the purpose of verifying and evaluating: (a) Benenson's compliance with the terms of this CIA; and (b) Benenson's compliance with the requirements of the Federal health care programs in which he participates. The documentation described above shall be made available by Benenson to OIG or its duly authorized representative(s) at all reasonable times for inspection, audit or reproduction. Furthermore, for the purposes of this provision, OIG or its duly authorized representative(s) may interview any of Benenson's employees, contractors, or agents who consent to be interviewed at the individual's place of business during normal business hours or at such other place and time as may be mutually agreed upon between the individual and OIG. Benenson shall assist OIG or its duly authorized representative(s) in contacting and arranging interviews with such individuals upon OIG's request. Benenson's employees may elect to be interviewed with or without a representative of Benenson present.

## VIII. DOCUMENT AND RECORD RETENTION

Benenson shall maintain for inspection all documents and records relating to reimbursement from the Federal health care programs, or to compliance with this CIA, for four (4) years (or longer if otherwise required by law).

## IX. DISCLOSURES

Consistent with HHS's FOIA procedures, set forth in 45 C.F.R. Part 5, OIG shall make a reasonable effort to notify Benenson prior to any release by OIG of information submitted by Benenson pursuant to his obligations under this CIA and identified upon submission by Benenson as trade secrets, or information that is commercial or financial and privileged or confidential, under the FOIA rules. With respect to such releases, Benenson shall have the rights set forth at 45 C.F.R. § 5.65(d). Benenson shall refrain from identifying any information as exempt from release if that information does not meet the criteria for exemption from disclosure under FOIA.

## X. BREACH AND DEFAULT PROVISIONS

Full and timely compliance by Benenson is expected throughout the duration of this CIA with respect to all of the obligations herein agreed to by Benenson.

### A. Stipulated Penalties for Failure to Comply with Certain Obligations

As a contractual remedy, Benenson and OIG hereby agree that failure to comply with certain obligations set forth in this CIA may lead to the imposition of the following

monetary penalties (hereinafter referred to as "Stipulated Penalties") in accordance with the following provisions.

1. A Stipulated Penalty of $1,000 (which shall begin to accrue on the day after the date the obligation became due) for each day Benenson fails to:

a. have in place a Compliance Contact as required in Section III.A;

b. post the notice required in Section III.B;

c. implement and make available the Policies and Procedures required in Section III.C;

d. require that Covered Persons attend the training required by Section III.D of the CIA within the time frames required in that Section;

e. retain an IRO within the timeframe required in Section III.E.1, or to submit the IRO's annual Claims Review Report or other report as required in Section III.E and Appendix A; or

f. meet any of the deadlines for the submission of the Implementation Report or the Annual Reports to OIG.

2. A Stipulated Penalty of $750 (which shall begin to accrue on the date the failure to comply began) for each day Benenson employs or contracts with an Ineligible Person and that person: (i) has responsibility for, or involvement with, Benenson's business operations related to the Federal health care programs; or (ii) is in a position for which the person's salary or the items or services rendered, ordered, or prescribed by the person are paid in whole or part, directly or indirectly, by Federal health care programs or otherwise with Federal funds (the Stipulated Penalty described in this paragraph shall not be demanded for any time period during which Benenson can demonstrate that he did not discover the person's exclusion or other ineligibility after making a reasonable inquiry (as described in Section III.C.5) as to the status of the person).

3. A Stipulated Penalty of $750 for each day Benenson fails to grant access to the information or documentation as required in Section VII of this CIA. (This Stipulated Penalty shall begin to accrue on the date Benenson fails to grant access.)

4. A Stipulated Penalty of $750 for each day Benenson fails to comply fully and adequately with any obligation of this CIA. In its notice to Benenson, OIG shall state

the specific grounds for its determination that Benenson has failed to comply fully and adequately with the CIA obligation(s) at issue and steps Benenson shall take to comply with the CIA. (This Stipulated Penalty shall begin to accrue ten (10) days after the date Benenson receives notice from OIG of the failure to comply.) A Stipulated Penalty as described in this paragraph shall not be demanded for any violation for which OIG has sought a Stipulated Penalty under paragraphs 1-3 of this Section.

B. Timely Written Requests for Extensions

Benenson may, in advance of the due date, submit a timely written request for an extension of time to perform any act or file any notification or report required by this CIA. Notwithstanding any other provision in this Section, if OIG grants the timely written request with respect to an act, notification, or report, Stipulated Penalties for failure to perform the act or file the notification or report shall not begin to accrue until one (1) day after Benenson fails to meet the revised deadline set by OIG. Notwithstanding any other provision in this Section, if OIG denies such a timely written request, Stipulated Penalties for failure to perform the act or file the notification or report shall not begin to accrue until three (3) business days after Benenson receives OIG's written denial of such request or the original due date, whichever is later. A "timely written request" is defined as a request in writing received by OIG at least five (5) business days prior to the date by which any act is due to be performed or any notification or report is due to be filed.

C. Payment of Stipulated Penalties.

1. *Demand Letter.* Upon a finding that Benenson has failed to comply with any of the obligations described in Section X.A and after determining that Stipulated Penalties are appropriate, OIG shall notify Benenson of: (a) Benenson's failure to comply; and (b) OIG's exercise of its contractual right to demand payment of the Stipulated Penalties (this notification is hereinafter referred to as the "Demand Letter").

2. *Response to Demand Letter.* Within ten (10) days of the receipt of the Demand Letter, Benenson shall respond by either: (a) curing the breach to OIG's satisfaction and paying the applicable Stipulated Penalties; or (b) sending in writing to OIG a request for a hearing before an HHS administrative law judge ("ALJ") to dispute OIG's determination of noncompliance, pursuant to the agreed upon provisions set forth below in Section X.E. In the event Benenson elects to request an ALJ hearing, the Stipulated Penalties shall continue to accrue until Benenson cures, to OIG's satisfaction, the alleged breach in dispute. Failure to respond to the Demand Letter in one of these two manners within the allowed time period shall be considered a material breach of this CIA

and shall be grounds for exclusion under Section X.D.

3. *Form of Payment.* Payment of the Stipulated Penalties shall be made by certified or cashier's check, payable to: "Secretary of the Department of Health and Human Services," and submitted to OIG at the address set forth in Section VI.

4. *Independence from Material Breach Determination.* Except as set forth in Section X.D.1.c, these provisions for payment of Stipulated Penalties shall not affect or otherwise set a standard for OIG's decision that Benenson has materially breached this CIA, which decision shall be made at OIG's discretion and shall be governed by the provisions in Section X.D, below.

**D. Exclusion for Material Breach of this CIA**

1. *Definition of Material Breach.* A material breach of this CIA means:

a. a failure by Benenson to report a Material Deficiency, take corrective action and make the appropriate refunds, as required in Section III.F;

b. a repeated or flagrant violation of the obligations under this CIA, including, but not limited to, the obligations addressed in Section X.A;

c. a failure to respond to a Demand Letter concerning the payment of Stipulated Penalties in accordance with Section X.C; or

d. a failure to retain and use an Independent Review Organization in accordance with Section III.E.

2. *Notice of Material Breach and Intent to Exclude.* The parties agree that a material breach of this CIA by Benenson constitutes an independent basis for Benenson's exclusion from participation in the Federal health care programs. Upon a determination by OIG that Benenson has materially breached this CIA and that exclusion shall be imposed, OIG shall notify Benenson of: (a) Benenson's material breach; and (b) OIG's intent to exercise its contractual right to impose exclusion (this notification is hereinafter referred to as the "Notice of Material Breach and Intent to Exclude").

3. *Opportunity to Cure.* Benenson shall have thirty (30) days from the date of receipt of the Notice of Material Breach and Intent to Exclude to demonstrate to OIG's

satisfaction that:

a. Benenson is in compliance with the obligations of the CIA cited by OIG as being the basis for the material breach;

b. the alleged material breach has been cured; or

c. the alleged material breach cannot be cured within the 30-day period, but that: (i) Benenson has begun to take action to cure the material breach; (ii) Benenson is pursuing such action with due diligence; and (iii) Benenson has provided to OIG a reasonable timetable for curing the material breach.

4. *Exclusion Letter.* If at the conclusion of the 30-day period, Benenson fails to satisfy the requirements of Section X.D.3, OIG may exclude Benenson from participation in the Federal health care programs. OIG shall notify Benenson in writing of its determination to exclude Benenson (this letter shall be referred to hereinafter as the "Exclusion Letter"). Subject to the Dispute Resolution provisions in Section X.E, below, the exclusion shall go into effect thirty (30) days after the date of the Exclusion Letter. The exclusion shall have national effect and shall also apply to all other Federal procurement and non-procurement programs. Reinstatement to program participation is not automatic. If at the end of the period of exclusion, Benenson wishes to apply for reinstatement, Benenson shall submit a written request for reinstatement in accordance with the provisions at 42 C.F.R. §§ 1001.3001-.3004.

## E. Dispute Resolution

1. *Review Rights.* Upon OIG's delivery to Benenson of its Demand Letter or of its Exclusion Letter, and as an agreed-upon contractual remedy for the resolution of disputes arising under this CIA, Benenson shall be afforded certain review rights comparable to the ones that are provided in 42 U.S.C. § 1320a-7(f) and 42 C.F.R. Part 1005 as if they applied to the Stipulated Penalties or exclusion sought pursuant to this CIA. Specifically, OIG's determination to demand payment of Stipulated Penalties or to seek exclusion shall be subject to review by an HHS ALJ and, in the event of an appeal, the HHS Departmental Appeals Board ("DAB"), in a manner consistent with the provisions in 42 C.F.R. §§ 1005.2-1005.21. Notwithstanding the language in 42 C.F.R. § 1005.2(c), the request for a hearing involving Stipulated Penalties shall be made within ten (10) days of the receipt of the Demand Letter and the request for a hearing involving exclusion shall be made within twenty-five (25) days of receipt of the Exclusion Letter.

2. *Stipulated Penalties Review.* Notwithstanding any provision of Title 42 of the United States Code or Chapter 42 of the Code of Federal Regulations, the only issues in a proceeding for Stipulated Penalties under this CIA shall be: (a) whether Benenson was in full and timely compliance with the obligations of this CIA for which OIG demands payment; and (b) the period of noncompliance. Benenson shall have the burden of proving its full and timely compliance and the steps taken to cure the noncompliance, if any. OIG shall not have the right to appeal to the DAB an adverse ALJ decision related to Stipulated Penalties. If the ALJ agrees with OIG with regard to a finding of a breach of this CIA and orders Benenson to pay Stipulated Penalties, such Stipulated Penalties shall become due and payable twenty (20) days after the ALJ issues such a decision unless Benenson requests review of the ALJ decision by the DAB. If the ALJ decision is properly appealed to the DAB and the DAB upholds OIG's determination, the Stipulated Penalties shall become due and payable twenty (20) days after the DAB issues its decision.

3. *Exclusion Review.* Notwithstanding any provision of Title 42 of the United States Code or Chapter 42 of the Code of Federal Regulations, the only issues in a proceeding for exclusion based on a material breach of this CIA shall be:

a. whether Benenson was in material breach of this CIA;

b. whether such breach was continuing on the date of the Exclusion Letter; and

c. whether the alleged material breach could not have been cured within the 30-day period, but that:

(i) Benenson had begun to take action to cure the material breach within that period;

(ii) Benenson has pursued and is pursuing such action with due diligence; and

(iii) Benenson provided to OIG within that period a reasonable timetable for curing the material breach and Benenson has followed the timetable.

For the purposes of the exclusion herein, exclusion shall take effect only after an ALJ decision favorable to OIG, or, if the ALJ rules for Benenson, only after a DAB decision in favor of OIG. Benenson's election of his contractual right to appeal to the DAB shall

not abrogate OIG's authority to exclude Benenson upon the issuance of an ALJ's decision in favor of OIG. If the ALJ sustains the determination of OIG and determines that exclusion is authorized, such exclusion shall take effect twenty (20) days after the ALJ issues such a decision, notwithstanding that Benenson may request review of the ALJ decision by the DAB. If the DAB finds in favor of OIG after an ALJ decision adverse to OIG, the exclusion shall take effect twenty (20) days after the DAB decision. Benenson shall waive his right to any notice of such an exclusion if a decision upholding the exclusion is rendered by the ALJ or DAB. If the DAB finds in favor of Benenson, Benenson shall be reinstated effective on the date of the original exclusion.

4. *Finality of Decision.* The review by an ALJ or the DAB provided for above shall not be considered to be an appeal right arising under any statutes or regulations. Consequently, the parties to this CIA agree that the DAB's decision (or the ALJ's decision if not appealed) shall be considered final for all purposes under this CIA.

## XI. EFFECTIVE AND BINDING CIA

Consistent with the provisions in the Settlement Agreement pursuant to which this CIA is entered, and into which this CIA is incorporated, Benenson and OIG agree as follows:

A. This CIA shall be binding on the successors, assigns and transferees of Benenson;

B. This CIA shall become final and binding on the date the final signature is obtained on the CIA;

C. Any modifications to this CIA shall be made with the prior written consent of the parties to this CIA;

D. If Benenson enters into an employment or contractual relationship with another party related to the furnishing of items or services that may be reimbursed by Federal health care programs, Benenson shall notify OIG within thirty (30) days of the date of the establishment of such relationship. Upon receipt of Benenson's notification, OIG may request information regarding the party's compliance program. OIG may agree to modify the CIA based on its evaluation of Benenson's new business relationship, his role in such relationship, and the party's compliance program;

E. OIG may agree to a suspension of Benenson's obligations under this CIA in

the event of Benenson's cessation of participation in Federal health care programs. If Benenson withdraws from participation in Federal health care programs and is relieved from his CIA obligations by OIG, Benenson shall notify OIG thirty (30) days in advance of Benenson's intent to reapply as a participating provider or supplier with the Federal health care programs Upon receipt of such notification, OIG shall evaluate whether the CIA shall be reactivated or modified; and

F. The undersigned Benenson signatories represent and warrant that they are authorized to execute this CIA. The undersigned OIG signatory represents that he is signing this CIA in his official capacity and that he is authorized to execute this CIA.

IN WITNESS WHEREOF, the parties hereto affix their signatures:

ALEXANDER BENENSON, M.D.

12.16.02
Date

ALEXANDER BENENSON, M.D.

12-16-02
Date

MARK L. HANKIN, ESQ.
Counsel for Benenson

OFFICE OF INSPECTOR GENERAL OF THE DEPARTMENT OF HEALTH AND HUMAN SERVICES

12/3/02
Date

Lewis Morris
Chief Counsel to the Inspector General
Office of Counsel to the Inspector General
U. S. Department of Health and Human Services

# APPENDIX A

## A. Billing Engagement's Claims Review.

1. Definitions. For the purposes of the Billing Engagement Claims Review, the following definitions shall be used:

a. Overpayment: The amount of money Benenson has received in excess of the amount due and payable under any Federal health care program requirements.

b. Item: Any discrete unit that can be sampled (e.g., code, line item, beneficiary, patient encounter, etc.).

c. Paid Claim: A code or line item submitted by Benenson and for which Benenson has received reimbursement from the Medicare program.

d. Population: All Items for which Benenson has submitted a code or line item and for which Benenson has received reimbursement from the Medicare program (i.e., a Paid Claim) during the 12-month period covered by the Claims Review. To be included in the Population, an Item must have resulted in at least one Paid Claim.

e. Error Rate: The Error Rate shall be the percentage of net Overpayments identified in the sample. The net Overpayments shall be calculated by subtracting all underpayments identified in the sample from all gross Overpayments identified in the sample. (Note: Any potential cost settlements or other supplemental payments should not be included in the net Overpayment calculation. Rather, only underpayments identified as part of the Discovery Sample or Full Sample (as applicable) shall be included as part of the net Overpayment calculation.)

The Error Rate is calculated by dividing the net Overpayment identified in the sample by the total dollar amount associated with the Items in the sample.

2. Other Requirements.

a. Paid Claims without Supporting Documentation. For the purpose of

appraising Items included in the Claims Review, any Paid Claim for which Benenson cannot produce documentation sufficient to support the Paid Claim shall be considered an error and the total reimbursement received by Benenson for such Paid Claim shall be deemed an Overpayment. Replacement sampling for Paid Claims with missing documentation is not permitted.

b. Use of First Samples Drawn. For the purposes of all samples (Discovery Sample(s) and Full Sample(s)) discussed in this Appendix, the Paid Claims associated with the Items selected in each first sample (or first sample for each strata, if applicable) shall be used. In other words, it is not permissible to generate more than one list of random samples and then select one for use with the Discovery Sample or Full Sample.

B. **Claims Review Report.** The following information shall be included in the Claims Review Report for each Discovery Sample and Full Sample (if applicable).

1. Claims Review Methodology.

a. Sampling Unit. A description of the Item as that term is utilized for the Claims Review.

b. Claims Review Population. A description of the Population subject to the Claims Review.

c. Claims Review Objective. A clear statement of the objective intended to be achieved by the Claims Review.

d. Sampling Frame. A description of the sampling frame, which is the totality of Items from which the Discovery Sample and, if any, Full Sample has been selected and an explanation of the methodology used to identify the sampling frame. In most circumstances, the sampling frame will be identical to the Population.

e. Source of Data. A description of the documentation relied upon by the IRO when performing the Claims Review (e.g., medical records, physician orders, certificates of medical necessity, requisition forms, local medical review policies, CMS program memoranda, Medicare carrier or intermediary manual or bulletins, other policies, regulations, or directives).

f. Review Protocol. A narrative description of how the Claims Review was conducted and what was evaluated.

2. Statistical Sampling Documentation.

a. The number of Items appraised in the Discovery Sample and, if applicable, in the Full Sample.

b. A copy of the printout of the random numbers generated by the "Random Numbers" function of the statistical sampling software used by the IRO.

c. A copy of the statistical software printout(s) estimating how many Items are to be included in the Full Sample, if applicable.

d. A description or identification of the statistical sampling software package used to conduct the sampling.

3. Claims Review Findings.

a. Narrative Results.

i. A description of Benenson's billing and coding system(s), including the identification, by position description, of the personnel involved in coding and billing.

ii. A narrative explanation of the IRO's findings and supporting rationale (including reasons for errors, patterns noted, etc.) regarding the Claims Review, including the results of the Discovery Sample, and the results of the Full Sample (if any) with the gross Overpayment amount, the net Overpayment amount, and the corresponding Error Rate(s) related to the net Overpayment.

b. Quantitative Results.

i. Total number and percentage of instances in which the IRO determined that the Paid Claims submitted by Benenson ("Claim Submitted") differed from what should have been the correct claim ("Correct Claim"), regardless of the effect on the payment.

ii. Total number and percentage of instances in which the Claim Submitted differed from the Correct Claim and in which such difference resulted in an Overpayment to Benenson.

iii. Total dollar amount of paid Items included in the sample and the net Overpayment associated with the sample.

iv. Error Rate in the sample.

v. A spreadsheet of the Claims Review results that includes the following information for each Paid Claim appraised: Federal health care program billed, beneficiary health insurance claim number, date of service, procedure code submitted, procedure code reimbursed, allowed amount reimbursed by payor, correct procedure code (as determined by the IRO), correct allowed amount (as determined by the IRO), dollar difference between allowed amount reimbursed by payor and the correct allowed amount. (See Attachment 1 to this Appendix).

4. Systems Review. Observations, findings, and recommendations on possible improvements to the system(s) and process(es) that generated the Overpayment(s).

5. Credentials. The names and credentials of the individuals who: (1) designed the statistical sampling procedures and the review methodology utilized for the Claims Review; and (2) performed the Claims Review.

Attachment 1

# Claim Review Results

| Federal Health Care Program Billed | Bene HIC # | Date of Service | Procedure Code Submitted | Procedure Code Reimbursed | Allowed Amount Reimbursed | Correct Procedure Code (IRO determined) | Correct Allowed Amt Reimbursed (IRO determined) | Dollar Difference between Amt Reimbursed and Correct Allowed Amt |
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ATTACHMENT 2

# NOTICE

**[Practitioner]** is committed to complying with all Federal health care program requirements in the operation of its businesses.

Anyone who has information or concerns about a possible violation of **[Practitioner's]** Policies and Procedures or any Federal health care program requirements should contact the Compliance Contact at *(___) ___-____* or via email at _____. Reporting may also be made anonymously by sending correspondence to:

*[Bob Jones*
*Physician Organization ABC*
*244 Circle Dr.*
*New Town, ST 10000*
*Fax: (123) 456-7788]*

# OVERPAYMENT REFUND

**TO BE COMPLETED BY MEDICARE CONTRACTOR**

Date:_____
Contractor Deposit Control #_____ Date of Deposit:_____
Contractor Contact Name:_____ Phone #_____
Contractor Address:_____
Contractor Fax:_____

**TO BE COMPLETED BY PROVIDER/PHYSICIAN/SUPPLIER**

*Please complete and forward to Medicare Contractor. This form, or a similar document containing the following information, should accompany every voluntary refund so that receipt of check is properly recorded and applied.*

PROVIDER/PHYSICIAN/SUPPLIERNAME_____
ADDRESS_____
PROVIDER/PHYSICIAN/SUPPLIER #_____ CHECK NUMBER#_____
CONTACT PERSON:_____ PHONE #_____
AMOUNT OF CHECK $_____ CHECK DATE_____

**REFUND INFORMATION**

**For each Claim, provide the following:**
Patient Name_____ HIC #_____
Medicare Claim Number_____ Claim Amount Refunded $_____
Reason Code for Claim Adjustment:_____ (Select reason code from list below. Use one reason per claim)

*(Please list all claim numbers involved. Attach separate sheet, if necessary)*

*Note: If Specific Patient/HIC/Claim #/Claim Amount data not available for all claims due to Statistical Sampling, please indicate methodology and formula used to determine amount and reason for overpayment:*_____

**For Institutional Facilities Only:**
Cost Report Year(s) _____
(If multiple cost report years are involved, provide a breakdown by amount and corresponding cost report year.)

**For OIG Reporting Requirements:**
Do you have a Corporate Integrity Agreement with OIG? _____ Yes _____ No

**Reason Codes:**

Billing/Clerical Error
01 - Corrected Date of Service
02 - Duplicate
03 - Corrected CPT Code
04 - Not Our Patient(s)
05 - Modifier Added/Removed
06 - Billed in Error
07 - Corrected CPT Code

MSP/Other Payer Involvement
08 - MSP Group Health Plan Insurance
09 - MSP No Fault Insurance
10 - MSP Liability Insurance
11 - MSP, Workers Comp.(Including Black Lung
12 - Veterans Administration

Miscellaneous
13 - Insufficient Documentation
14 - Patient Enrolled in an HMO
15 - Services Not Rendered
16 - Medical Necessity
17 - Other (Please Specify)
_____